Illinois Health and Hospital Association

October 27, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, D.C. 20201

Re: CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (85 FR 54820)

Dear Ms. Verma:

On behalf of our more than 200 member hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) interim final rule with comment period that revises regulations specific to the Medicare and Medicaid programs in response to the COVID-19 public health emergency (PHE). IHA commends CMS' work, be it via flexibilities in telehealth or recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS), to enhance the abilities of providers across the country to prepare for and respond to the ongoing PHE. Specifically, we agree with the administration that timely and accurate data regarding the incidence and spread of COVID-19, as well as hospital capacity, is essential to addressing the virus and distributing a vaccine once one becomes available. Thus, we value the opportunity to engage the administration on data collection efforts. We want to work with our CMS partners to ensure that collected data are appropriate in informing our collective response to the PHE moving forward, and that the process for reporting these data do not hinder providers from providing needed care not only for COVID-19, but for the many other health issues that Americans regularly face.

To that end, we urge CMS to reconsider making COVID-19 data reporting a Condition of Participation (CoP). Enforcing data reporting via CoPs seems draconian, especially because many Illinois hospitals that are not in 100 percent compliance are striving to achieve this goal, yet struggle to do so due to persistent confusion around the rollout of the data reporting process and the data elements currently required. Not only do many of our hospitals, particularly rural and safety net hospitals, rely on Medicare and Medicaid to remain open, but the communities they serve also depend on these programs to access the healthcare they need to lead active and fruitful lives. Jeopardizing that access will exacerbate the healthcare disparities that COVID-19 has

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highlighted, curtailing access for our most vulnerable populations at a time when they arguably need it the most.

Regarding the reporting process, CMS acknowledges both in the interim final rule and the accompanying reporting guidance that how and what hospitals must report COVID-19 data has changed several times over the course of the PHE. In conversations with Illinois hospitals, it is clear that the ever-changing reporting process is a source of confusion that has directly affected hospital operations including accessing funds from the Provider Relief Fund and securing appropriate shares of Remdesivir. Thus, moving forward we urge the administration to continue with the process in place today, using the same platforms and interfaces that are currently in operation.

We also ask HHS to clarify reporting requirements for items 27-32. Specifically, we ask HHS to state whether providers must reply at the facility level, system level, or whichever is applicable, such as the guidance for item 26. While such guidance may seem prescriptive, with Medicare and Medicaid participation on the line, the administration should eliminate all ambiguity in the reporting process. IHA is ready to communicate such guidance to hospitals upon its release.

Regarding the addition of items 33-37 (Influenza), the guidance states additional information is forthcoming. In the future, we suggest the administration consider releasing complete and comprehensive guidance on the addition or deletion of data items in one release rather than rely on progressive communications. This will help eliminate confusion, which may inadvertently cause hospitals to be out of compliance in the future.

We thank HHS for providing additional guidance on the reporting process via webinars held Oct. 20 and 22. We also thank HHS for creating the HHS Protect Service Desk to assist providers with the reporting process. However, we have heard from our members and several hospitals in other states that there are discrepancies between what hospitals submit and what the Centers for Disease Control and Prevention receive. Addressing these discrepancies will not only foster a more amicable relationship between the federal government and providers, but also maximize efficiency and lead to better data submissions moving forward.

Ms. Verma, thank you again for the opportunity to comment on this interim final rule.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association